1-15	Individual or Family Service Plan	Part 1 of 3
Authorizing Utah Code: 62a-5-103	Rule: None	Rights and Protections
Approved: 8/12/99	Rule Effective: n/a	Printed: 5/02
Form(s):1-15I, 1-15, 1-15A, 817 and 1056		Guideline(s): None

POLICY

The **Individual Service Plan (ISP) Form** 1-15 is developed based on supports listed in the **Person-Centered Plan** and other supports identified as important to the **Person**. The **Individual Service Plan** may be developed at the same time or immediately after the **Person**-**Centered Plan** (see **Division** Policy 1-16). If the **Person** receives family support, a **Family Service Plan (FSP) Form** 1-15 may be developed. The **Family Service Plan** shall outline what the family needs to support the family member with a disability, as well as the needs of the **Person** with a disability. For **Person**s receiving only family support services, the **Family Service Plan** may be used in place of both the **Individual Service Plan** and the **Person**-**Centered Plan**.

PROCEDURES

1. The **Individual** or **Family Service Plan** (hereafter referred to as **Form 1-15**) is the fundamental tool used by the **Division** to ensure services, supports, life activities and health and safety supports meet the **Person**'s needs and prevent institutionalization if the **Person** is receiving **Waiver** services.

   A. Prior to the provision of any support coordinator services a **Form 1-15**I will be completed so that support coordination activities can be claimed. The **Form 1-15**I opens the person for support coordination services, and requires the signature of the **Person/Representative** and **Qualified Mental Retardation Professional**.
   B. Prior to the delivery of **Provider** services, a **Person**-**Centered Plan** and **Form 1-15** must be completed by the **Support Coordinator** and filed in the **Person**'s record.
   C. The **Form 1-15** must contain the following required components:
      i. effective date;
      ii. name, phone and address of **Person**;
      iii. **Support Coordinator**'s name, phone and office location;
      iv. all **Waiver** and non-**Waiver** services needed by the **Person**, regardless of the funding source, including support coordination, if applicable;
      v. documentation that the **Person/Representative** were provided a choice between receiving services at an Intermediate Care Facility for People with Mental Retardation (ICF/MR) or in the community;
      vi. documentation that the **Person** was given a choice of **Provider**s. If **Person** was not provided a choice of **Provider**s, the **Support Coordinator** advises the **Person** of hearing procedures and provides a copy of Policy 1-5, Notice of Hearing for **Agency Action**,
      vii. documentation that the **Person** received instruction on human rights and a copy of Policy 1-1, Human Rights;
      viii. expected start date, intensity, frequency and duration of each support including all supports to be provided;
      ix. the type of **Provider** who will furnish each support; and
      x. dated signatures from the **Person**/**Representative** and **Support Coordinator**.

D. If the **Family Service Plan Form** 1-15 is to be used as a **Person-Centered Plan**, the **Form 1-15** must contain the following additional components:

i. an assessment of the abilities of the **Person** with a disability;
ii. an assessment of the concerns and priorities of the **Person** and family including what will enhance the life of the **Person** with a disability;
iii. action steps in implementing the plan to meet the **Person**'s and family's desired outcomes;
iv. an outline of responsibilities of the family, **Division**, **Provider**s, etc., to implement the plan;
v. timelines the **Team** members are expected to meet; and
vi. dated signatures of all **Team** members.

E. If a **Family Service Plan** is being completed, the **Support Coordinator** shall:

i. assist the family to establish a schedule or process to review the action plan notes and information collected by **Provider**s for accuracy;
ii. provide all **Team** members a copy of the plan; and
iii. assist and support the family to take primary responsibility for the development, coordination, and evaluation of supports.

F. The **Form 1-15** shall be approved and signed by the **Person/Representative**, the **Qualified Mental Retardation Professional**, the **Support Coordinator** and others, as necessary and appropriate.

G. The **Support Coordinator** is responsible for ensuring that the **Person** receives the supports identified in the **Form 1-15** and that the **Person**, legal **Guardian**, and all involved **Provider**s receive a copy of the **Form 1-15**.

H. For paid supports, **Division Form 1056** shall be used to establish the purchase of service and set authorized spending limits.

2. Periodic Review of the **Form 1-15**

A. The **Support Coordinator** is responsible for ensuring that the **Form 1-15** is reviewed and updated as necessary to:

i. record the **Person**'s progress (or lack of progress);
ii. determine the continued appropriateness and adequacy of the **Person**'s services; and
iii. ensure that the services identified in the **Form** 1-15 are in fact being delivered and are appropriate for the **Person**.

B. The **Form 1-15** is updated or revised as necessary by the **Support Coordinator** in consultation with the **Person**/**Representative** and others as appropriate. A formal review of the **Form 1-15** must be done at least annually within the calendar month in which it is due. The annual review meeting must involve at least the **Person**/**Representative** and **Support Coordinator**. In this meeting, the supports provided may be changed.

3. Once a year, the eligibility and **Level of Care** for everyone who receives services under a Medicaid **Waiver** is reviewed. This process is known as "**Waiver** re-certification." **Waiver** re-certification requires the **Support Coordinator** to:

A. annually review the **Person**'s **Level of Care** within the calendar month in which it is due;

B. determine that the **Person** continues to meet the Intermediate Care Facility for People with Mental Retardation (ICF/MR) **Level of Care** criteria and that the **Person**'s needs are met, and can continue to be met, in the community;

C. review the documentation considered for the previous **Level of Care** determination as well as any new information available and update the information or document why an update is not necessary;

D. document the **Level of Care** recertification on **Form 817**; and

E. provide hearing rights as instructed in Policy 1-5 to anyone found to no longer be eligible for **Waiver** services.